WorkHealth

Occupational Medical Center

Employee Name: ______________________________

Employer Central State Community Services **Job Title:** ______________________________

FACILITY ADDRESS

Work-related – Date of Injury- __________	**Physical Exam Options**
☐ Injury	☐ Post offer/Pre-Hire
☐ Illness	☐ DOT ☐Initial ☐Recert
Drug Testing Options	☐ Return to Work
☐ DOT FMCSA☐PHMSA☐ FAA☐FRA☐ FTA☐	☐ Annual
☐ Non-DOT USCG ☐	**Other**
Reason:	☐ Audiogram
☐ Post offer/Pre-hire	☐ Back Evaluation
☐ Post Injury	☐ Chest X-Ray
☐ Post Accident	☐ EKG
☐ Reasonable Cause	☐ Lift Test
☐ Recertification	☐ Hepatitis B Vaccine
☐ Random Drug Screen	☐ PPD Test
☐ Periodic	☐ Pulmonary Function Test (PFT)
☐ Follow-up	☐ Tetanus
	☐ Other __________
☐ Evidential Breath Alcohol Test	

Special Instructions:

☐ Follow regular protocol for specified job description

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Authorized by: [signature] (Signature) Kari Conner (Please Print)

Phone: (989)631-6691 Date: __________

Consent for Release of Information:

I hereby authorize **WorkHealth** Occupational Medical Center, its practitioners and staff, to release any information pertinent to this specific injury/illness and/or physical examination and/or drug or alcohol screen results to my Employer, Prospective Employer, Employer's Medical Review Officer, or Third Party Administrator. IN addition, I hereby release **WorkHealth** Occupational Medical Center, its practitioners and staff, from any and all claims of actions resulting from the disclosure of these results.

I hereby give consent to **WorkHealth** Occupational Medical Center, its practitioners and staff, for examination and treatment.

Employee/Patient Signature______________________________ Date: __________

** WorkHealth does not collect genetic information
** WorkHealth does not provide genetic information
** Picture ID is required for all substance abuse testing/drug screening.

** Please do NOT bring children to the clinic